

**MEDICAL BALANCE BILLING: INADEQUATE REGULATIONS, INCREASING CONSUMER
OUTRAGE, AND COMPETING ECONOMIC INTERESTS – HOW DO WE FIX IT?**

By: Chrissie O'Neill¹

Introduction

Healthcare spending in the United States topped \$2.9 trillion dollars in 2013 with per capita healthcare spending at approximately \$9,255.² Industry experts have many theories to explain such high costs, including excessive administrative outlays and the fact that Americans both pay higher prices for care and receive more healthcare than citizens in many other developed countries.³ Because of the high cost burden and the amount of care received, unpaid medical bills tend to quickly add up.⁴ High medical bills do not discriminate; they affect both the insured and uninsured and are the leading cause of bankruptcy in the United States surpassing both credit card debt and unpaid mortgages.⁵

Even outside of bankruptcy, CNBC estimated that twenty percent of the population between ages 19 and 64 struggled to pay their medical bills in 2013.⁶ According to the Centers for Disease Control and Prevention (“CDC”), that estimate is conservative.⁷ The CDC found that more than one in four families faced the financial burden of funding medical care.⁸ Broken down further, one in six families had problems paying medical bills in the past year and one in ten were unable to pay *at all*.⁹ The prevalence of medical debt can be partially attributed to the difficulty and confusion that befalls consumers when initially selecting health insurance coverage.¹⁰ Consumers tend to believe that once they secure medical insurance they will be protected against personal loss and suffering from everyday medical issues to life-changing accidents and illnesses.¹¹ Unfortunately, this is not always the case.¹² In fact, a sizeable number of

consumers do not understand how insurance plans work, exactly what the plans cover, and which providers are within or outside of their covered network.¹³ When Massachusetts opened its online insurance exchange in 2007, as many as forty percent of users found the cost information unclear or difficult to understand.¹⁴ This problem has yet to be completely solved. Consumers nationwide struggle with insurance and billing literacy with some calling the new changes to the healthcare system under the Affordable Care Act (“ACA”), “...obscure, scary and downright befuddling.”¹⁵

Although the population may have a lack of clarity regarding the ACA, the controversial law has considerably expanded insurance coverage and is projected to save hospitals \$5.7 billion dollars in previously uncompensated hospital care often referred to as write-offs or charity care.¹⁶ Under the long-standing federal Emergency Medical Treatment and Labor Act (“EMTALA”), patients have already been guaranteed access to emergency medical care regardless of ability to pay.¹⁷ The insurance expansion under the ACA was intended to ensure patients have less difficulty paying for emergency care mandated under EMTALA.¹⁸ The United States government has successfully increased overall access to care and guaranteed patient care in emergencies, but what actually happens after patients receive that lifesaving care?

The answer to this question differs by state and gives rise to a nationwide dilemma known as “balance billing” – often referred to as the “black scourge” of the insurance industry.¹⁹ Balance billing occurs when a hospital or individual physician attempts to collect from the patient the difference between what the hospital and/or physician originally billed and what the health plan [insurer] actually paid.²⁰ Another explanation is that a physician or hospital will accept some level of reimbursement from

an insurer and then bill the patient above that amount to bring in extra revenue.²¹ Some critics argue that the ACA will contribute to increases in these surprise balance bills because some state exchange health plans only cover in-network care or fail to disclose payment policies when physicians, nurses, and other medical professionals fall outside a patient's insurance network.²² However, recent statistics indicate that the ACA has actually had a significant impact on affordability overall.²³

In fact, The Commonwealth Fund Report states that, “[i]n 2014, insured adults also reported fewer problems getting care because of concerns about costs for the first time since 2005,” suggesting long-awaited gains in affordability of healthcare.²⁴ Supporters of the ACA credit the increased affordability of care to the ban on coverage discrimination for those with preexisting conditions, essential health benefit package guarantees, and the improving economy.²⁵ Although these are promising indicators, it remains to be seen if this downward cost trend in healthcare will continue going forward and the question remains about whether it will help eliminate balance billing. Some states are not convinced and have taken action individually because there are no concrete projections of affordability in years to come.²⁶

Analysis

Despite some isolated state action, the United States needs a widespread solution to help patients cope with often crushing medical debt. It is simply unacceptable that thirty-five percent of Americans are still struggling to pay medical bills in 2014.²⁷ Thankfully, some states have begun to take action – most notably Texas and New York.

1. Texas

In 2009, Texas Governor Rick Perry signed a law creating a new right for consumers in balance billing disputes with out of network providers.²⁸ First, it is important to note that beyond the mediation law, Texas does not regulate balance billing by out of network providers outright, even in emergency cases.²⁹ As a result, if someone is involved in an accident and taken to the nearest hospital that happens to be outside their network, the patient will have no control over the costs even if they have insurance. According to the Texas Department of Insurance, patients must be enrolled in a preferred provider organization (PPO) plan or a be member of a special Texas retiree insurance plan and bills must exceed \$1,000 in order to qualify for the mediation process under the statute.³⁰ Because of this PPO or retiree requirement, not all citizens of Texas are eligible for mediation – they must fall into one of those specific categories.³¹

Additionally, under Texas law, patients only have a right to seek mediation if the hospital-based physician did not make a “complete and accurate disclosure” before providing the service as required by Texas law.³² If that is the case, the insurer and provider will be required to participate in the mediation process.³³ In other words, if a physician discloses that they are out of network and later balance bills you, the patient will not be entitled to state mediation under the statute.³⁴ However, if the physician neglects to disclose his out of network status, he and the relevant insurer will be required to participate in the mediation process if the patient makes a request with the Texas Department of Insurance.³⁵ The Texas regulation gives patients the option to participate in the mediation or allow their insurer and the provider to negotiate independently and all requests for mediation must be filed though the Department of Insurance.³⁶

Patients are not required to seek mediation through the aforementioned process, but the regulation grants them a new right to do so if they qualify.³⁷ Providers and insurers are required to participate in the mediation via an initial telephone conference within 30 days of the patient request and an official conference is required within 180 days of the request.³⁸ If the mediation is unsuccessful, the patient may be able to seek a resolution in court – the regulation makes it clear that attempting mediation does not eliminate the right to take the issue to court.³⁹ The physician cannot attempt to collect any payment (other than copayments, deductibles, or coinsurance) until the mediation process is resolved or the request is withdrawn.⁴⁰ Although the law seems to be a step in the right direction, its highly specific criterion leaves much to be desired and does not protect all patients.

2. New York

Unlike Texas, New York's approach to managing balance billing removes the patient from the process altogether.⁴¹ The state chose to create a binding arbitration process as a matter of last resort.⁴² Prior to seeking independent dispute resolution, the insurer must provide reimbursement equivalent to what an in-network provider would receive.⁴³ If the provider still seeks additional payment, the parties engage in negotiations of their own and if no resolution can be reached, either the insurer or the provider can submit the claim for binding arbitration.⁴⁴

On its face, the New York statute succeeds in both leaving the patient out of the fee dispute and protecting *all* patients regardless of who their insurer is or the amount of the bill. The New York approach is a marked improvement from the Texas law from a

patient perspective because it applies to all patients and not just those that fulfill extremely specific criteria.

Additionally, the New York statute takes the patients out of the process and does not require them to evaluate criteria or to file a request with the state department of insurance, unlike the Texas law.⁴⁵ The argument over fees is left to the provider and insurer so a patient who required emergency care or was unable to select a doctor because of the nature of care required will not be held liable for additional costs above their typical copayment, coinsurance, or deductible rates.⁴⁶ Providers will be guaranteed at least what they would have received if they were in network, and possibly more if they are able to negotiate additional payment with the insurer or during a binding arbitration process.⁴⁷ The New York statute will effectively protect all patients against rampantly high balance bills in emergency and other cases where they are unable to select their provider in advance once fully enacted in March 2015.

Conclusion

A large-scale remedy from Congress would be the most helpful change, but because Congressional action can be difficult to achieve because of partisan allegiances, it is more likely that action will occur in individual states. Judging by the uptick in the media coverage on balance billing issues, more states will likely begin listening to their consumers and aim to fix the problems on their own. It is extremely likely that the New York Surprise Bill Law will act as a model for balance billing reform once it is fully enacted in 2015 and the state has the opportunity to work out any kinks in its application. Other states should follow the New York approach to restrict balance billing in emergencies and when patients are unable to choose their own doctors. Patients should

not be responsible for negotiating additional payment to a provider when they were diligent and secured insurance. Providers and insurers should be able to negotiate amongst themselves what a fair price is for life-saving medical care – the patient should be removed from that equation. If patients pay premiums and must meet a deductible as per their insurer, they should be able to sleep soundly knowing that their insurance is in fact protecting them from a catastrophic financial loss. The highly specific criteria required to seek mediation in Texas prohibits patients who are unable to understand the regulation from seeking a remedy, and even those who do understand the complexities may not be eligible. Forcing providers and insurers to negotiate reasonable out of network reimbursement rates in emergency situations will prevent patients from financial ruin, guarantee providers receive adequate, market-value compensation for their services, and ensure that insurers are not paying out excessive claims while maintaining their commitment to their enrollees.

Critics may argue that patients should get better insurance, make their preferences known, or simply pay the extra associated costs with emergency care. However, supporters may agree patients should not be punished for unforeseen circumstances especially when they believed their medical insurance would protect them from unreasonable expenditures. Balancing the needs of all the players in the United States' healthcare system is a delicate endeavor, but ultimately providers need to stop bankrupting individuals for an extra payday.

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²National Health Expenditure Data, CTR. FOR MEDICARE & MEDICAID SERVICES (last modified Dec. 9, 2014, 6:26 AM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

³ David Cutler, *Why does health care cost so much in America? Ask Harvard's David Cutler*, PBS NEWSHOUR (Nov. 19, 2013, 5:28 PM), <http://www.pbs.org/newshour/rundown/why-does-health-care-cost-so-much-in-america-ask-harvards-david-cutler/>.

⁴ Dan Mangan, *Medical Bills Are the Biggest Cause of US Bankruptcies: Study*, CNBC (Jun. 25, 2013, 2:29 PM), <http://www.cnbc.com/id/100840148#>.

⁵ *Id.*

⁶ *Id.*

⁷ Robin A. Cohen & Whitney K. Kirzinger, *Financial Burden of Medical Care: A Family Perspective*, CTR. FOR DISEASE CONTROL & PREVENTION (Jan. 2014), available at <http://www.cdc.gov/nchs/data/databriefs/db142.htm> (last modified Jan. 28, 2014).

⁸ *Id.*

⁹ *Id.*

¹⁰ Sarah Kliff, *Buying Health Coverage is Insanely Confusing, Can Obamacare Fix That?*, THE WASHINGTON POST (Jan. 30, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/30/buying-health-coverage-is-insanely-confusing-can-obamacare-fix-that/>.

¹¹ Tricia Spencer, *Balanced Billing is the Ugly Beast of Medical Insurance*, Huffington Post Business Blog (Aug. 4, 2014, 5:59AM), http://www.huffingtonpost.com/tricia-spencer/balanced-billing-is-the-obamacare_b_5419026.html.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Olga Khazan, *Why People Find Obamacare so Confusing*, THE ATLANTIC (Jan. 2, 2014), <http://www.theatlantic.com/health/archive/2014/01/why-people-find-obamacare-so-confusing/282747/>.

¹⁶ Robert Pear, *Affordable Care Act Reduces Costs for Hospitals, Report Says*, THE NEW YORK TIMES, (Sep. 24, 2014), http://www.nytimes.com/2014/09/25/us/health-act-cuts-spending-at-hospitals-report-finds.html?emc=edit_tnt_20140924&nliid=58462464&tntemail0=y&_r=1. See also Ziva Branstetter et al., *Hospitals Spend Small Fractions of Revenue on Charity Care*, OKLAHOMA WATCH (Nov. 1, 2013), <http://oklahomawatch.org/2013/11/01/hospitals-spend-small-fractions-of-revenue-on-charity-care/> (using Oklahoma hospitals as an example of how hospitals only spend a fraction of what they claim on charity care).

¹⁷ 42 USCS § 1395(d)(d).

¹⁸ Pear, *supra* note 16.

¹⁹ Spencer, *supra* note 11.

²⁰ Michelle Andrews, *Beware of Higher Charges if You Go to an Out-of-Network Emergency Room*, KAISER HEALTH NEWS (Aug. 29, 2014), <http://www.kaiserhealthnews.org/stories/2014/august/29/beware-of-higher-charges-if-you-go-to-an-out-of-network-emergency-room.aspx?referrer=search>.

²¹ *Id.*

²² Abby Goodnough et al., *Has Insurance Under the Law Been Affordable?*, THE NEW YORK TIMES, (Oct. 26, 2014), http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html?module=Search&mabReward=relbias%3Ar%2C%7B%222%22%3A%22RI%3A15%22%7D&_r=0#/.

²³ Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, & Sophie Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014*, The Commonwealth Fund, (Jan. 2015), http://www.commonwealthfund.org/~media/files/publications/issuebrief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en.

²⁴ *Id.* at 4.

²⁵ *Id.* at 4.

²⁶ Mangan, *supra* note 4.

²⁷ Collins, *supra* note 23, at 5.

²⁸ Texas Dept. of Insurance, *Mediation for Out-of-Network Hospital-based Health Care Provider Claims*, <http://www.tdi.texas.gov/consumer/cpmmediation.html> (last visited Feb. 17, 2015).

²⁹ *State Restriction Against Providers Billing Managed Care Enrollees*, KAISER FAMILY FOUNDATION, <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/> (last visited Nov. 12, 2014).

³⁰ TDI, *supra* note 28.

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ TDI, *supra* note 28.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ TDI, *supra* note 28.

⁴¹ Caroline Chen, *Surprise Medical Bills Lead to Protection Laws: Health*, BLOOMBERG NEWS (Apr. 4, 2014, 12:01 AM) <http://www.bloomberg.com/news/2014-04-04/surprise-medical-bills-lead-to-protection-laws-health.html>.

⁴² NY CLS FINANCIAL SERVICES LAW § 607.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Compare* NY CLS FINANCIAL SERVICES LAW § 607, *with* Texas Dept. of Insurance, *Mediation for Out-of-Network Hospital-based Health Care Provider Claims*, <http://www.tdi.texas.gov/consumer/cpmmediation.html> (last visited Feb. 17, 2015) (where NY mandates providers engage in reimbursement negotiations and only then may the provider or insurer seek binding arbitration versus in Texas where the patient is responsible for submitting a request for mediation to the state department of insurance).

⁴⁶ *Supra* note 28.

⁴⁷ *Id.*